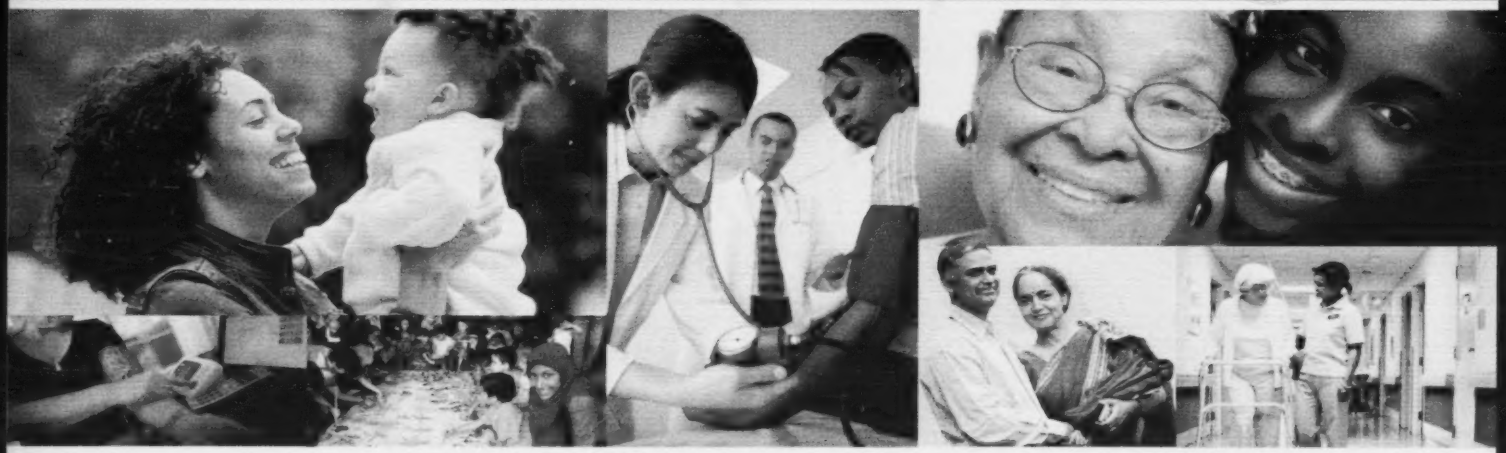
Central West **LHIN**



ANNUAL BUSINESS PLAN 2017-2018

Making HEALTHY Change Happen

Ontario
Local Health Integration Network

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GLOSSARY

The following glossary provides quick reference to the most commonly used acronyms throughout this document.

ABP	Annual Business Plan
ALC	Alternate Level of Care
CAG	Core Action Group
CCAC	Community Care Access Centre
CHC	Community Health Center
CSS	Community Support Service
CWPCN	Central West Palliative Care Network
ED	Emergency Department
EMR	Electronic Medical Record
FHG	Family Health Group
FHO	Family Health Organization
FHT	Family Health Team
FLS	French Language Service(s)
HEIA	Health Equity Impact Assessment
HHCC	Headwaters Health Care Centre
HRM	Hospital Report Manager
HSP	Health Service Provider
HQO	Health Quality Ontario
IAC	Indigenous Advisory Circle
IHSP	Integrated Health Service Plan
IM	Information Management
IT	Information Technology
LHIN	Local Health Integration Network
LHSIA	Local Health System Integration Act
LTC	Long-Term Care
MOHLTC	Ministry of Health and Long-Term Care
OTN	Ontario Telemedicine Network
PACE	Program for All-inclusive Care for the Elderly
RQT	Regional Quality Table
SPO	Service Provider Organization

A Message from the Board Chair & CEO

In support of its three year strategic plan, more commonly referred to as an Integrated Health Service Plan (IHSP) 2016-2019, the Central West Local Health Integration Network (LHIN) is pleased to present its Annual Business Plan for fiscal year April 1, 2017 through March 31, 2018 (ABP 2017/18).

Of note, ABP 2017/18 identifies the activities that will support the work to be accomplished during the second year of IHSP 2016-2019. It also takes into account the activities designed to specifically support the LHIN during a period of exciting and transformative change.

In support of Ontario's Patients First Act, the Central West Community Care Access Centre (CCAC) and Central West Local Health Integration Network (LHIN) will ensure readiness to transition under a new LHIN banner by May 1, 2017.

Designed to enable a more patient-centered health care system in Ontario, the Patients First Act is an important component of the government's *Patients First*: Action Plan for Health Care. Implementation of this new legislation will improve local connections between primary care providers, inter-professional health care teams, hospitals, public health and home and community care, enabling improved patient experiences and smoother transitions.

Bringing together the best of their respective legacy organizations, both the Central West CCAC and LHIN are committed to ensuring the seamless transition of programs and services both on transition day and beyond. Of equal importance will be the seamless transition of staff into a new LHIN organization.

For 2017/18, a balance must exist between the need to carry out important transitional work and ensuring the continuity of current LHIN operations to advance key strategic directions and initiatives. As a result, ABP 2017/18 represents a refined, focused and targeted approach to the work that lies ahead.

While Ontario's health care system has improved significantly over the past decade continued work is required, in particular to achieving a genuinely integrated system. Through the implementation of the Patients First Act, the Central West LHIN remains committed to improving access, connecting

services, supporting people and patients and protecting the local health care system now and for future generations.

Both residents and health care professionals alike place high value on their health care system and its need to be responsive to local communities. The LHIN's Board of Directors and staff thank Health Service Providers (HSPs) and community partners who have taken ownership and accountability for meaningful change, and local residents who continue to play an active role in shaping their local health care system. Collectively, this ongoing dedication and commitment toward the provision of high-quality, patient-centred health care is transforming a bold vision into reality.

Together, Making Healthy Change Happen

Carmine Domanico
Board Chair

Scott McLeod
CEO

Overview

ABP 2017/18 is the Central West LHIN's work plan for fiscal year April 1, 2017 through to March 31, 2018. It identifies those activities that will support work to be accomplished during the second year of IHSP 2016-2019. It also takes into account those activities designed to specifically support the LHIN during a period of exciting and transformative change.

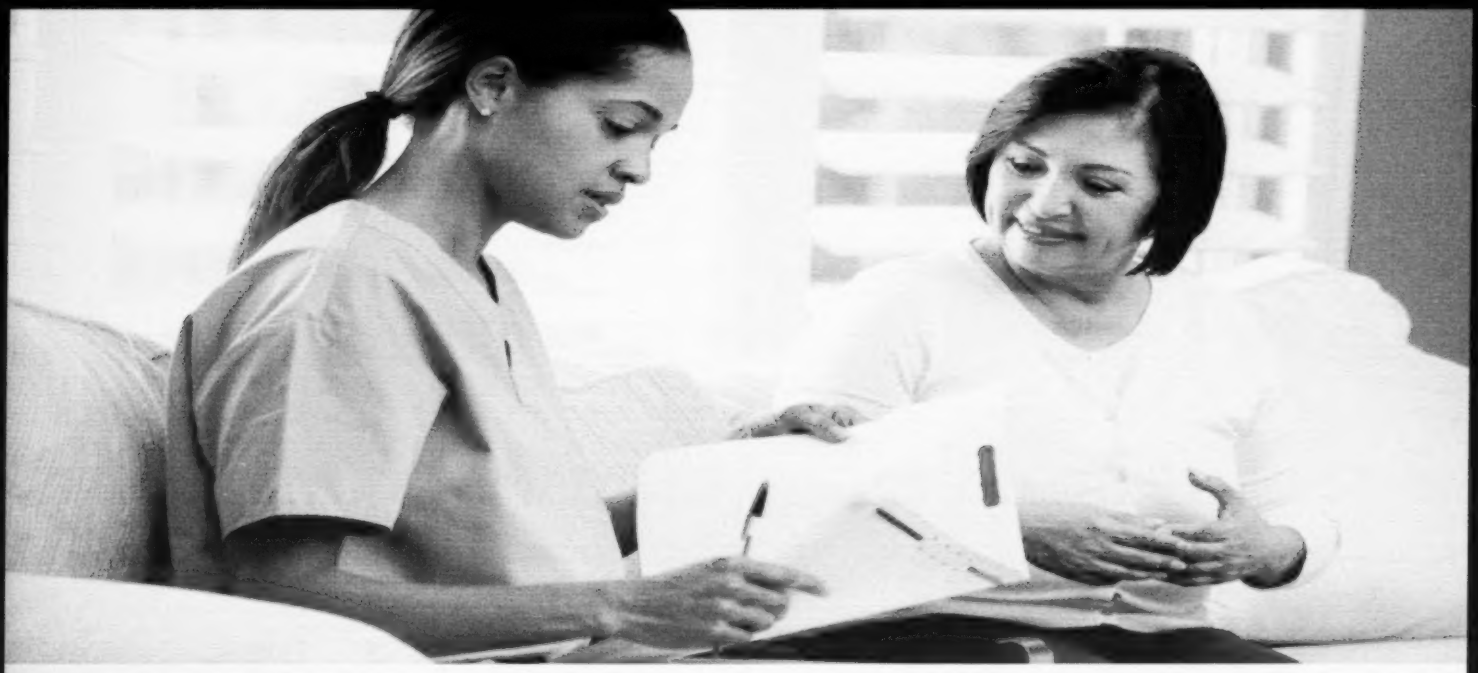
Section 1 | Context... Provides an overview of the Central West LHIN's mandate, strategic directions, and provincial alignment. It also includes an environmental profile (population and health) of local residents, a summary of current LHIN activities, and an overview of the LHIN's commitment and plan to ensure the effective provision of programs and services to both Francophone and Indigenous peoples within LHIN communities.

Section 2 | Operationalizing the Priorities... Outlines key activities the Central West LHIN will undertake in 2017/18 to support the strategic directions of IHSP 2016-2019. These activities will also drive system change in alignment with government priorities. Included in this section are performance measures and targets that will be used to measure progress, and an understanding of potential risks/barriers to successful implementation.

Section 3 | LHIN Operations... Provides a three-year spending plan for Central West LHIN operations, including a summary of current and proposed staffing levels.

Section 4 | Communications and Community Engagement... Describes Central West LHIN communications and community engagement goals, objectives and evaluation measures for the coming fiscal year.

The Central West LHIN in partnership with the Ministry of Health and Long-Term Care (MOHLTC), HSPs, community partners and local residents is working to ensure a sustainable, high-quality, and person-centred local health care system exists for current and future generations. The Central West LHIN's 2017/18 Annual Report will highlight the success of ABP 2017/18 and chronicle the LHIN's accomplishments towards placing patients first and ensuring the needs of LHIN residents remain at the centre of the local health care system.



Context

The Central West Local Health Integration Network (LHIN) was established under the *Local Health System Integration Act (LHSIA) - 2006*, and was given the authority to plan, fund, integrate and monitor the local health care system for the purpose of improving the health of residents who live in communities within its geographic boundaries. These communities include Brampton, Caledon, Dufferin County, Malton, North Etobicoke, and West Woodbridge.

Mission

For the LHIN to drive change, it must remain committed to its mission. The mission represents the LHIN's core responsibility, and is the focal point for how the LHIN will achieve its vision:

To improve access to, and the quality of, health services for residents of the Central West LHIN, through strengthened integration and coordination of health services.

Vision

Based on Ontario's *Patients First*: Action Plan for Health Care, the LHIN's vision represents its aspirations for the local health care system:

Residents of the Central West LHIN will have better and faster access to high-quality health services. They will have better information so they can make decisions that will help them live and stay healthy. Their services will be protected to ensure they are sustainable for future generations.

Values

As the LHIN works to achieve its mission and vision, its actions and decisions are underpinned and grounded in a set of core values:

Person-Centred Care: With purpose and passion, we work with individuals and the community to advance the public good, and we place people and patients first, ensuring the needs of LHIN residents remain at the centre of their local health care system.

Transparency: A commitment to the highest possible ethical standards, and open and timely sharing of information.

Integrity: In all of our activities, we will foster trust by being truthful, empathetic and consistent.

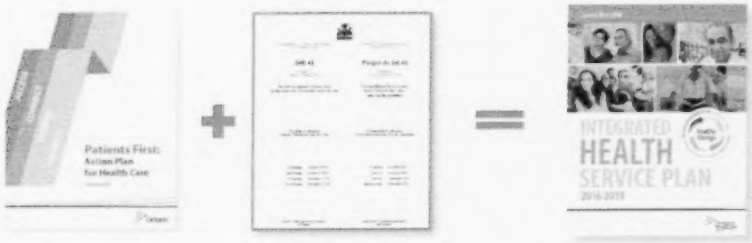
Stewardship: In managing all resources for which we have been entrusted, we will seek ways to ensure appropriate use of resources, and act responsibly, taking actions that align with our vision, values and strategic directions.

Strategic & Operational Alignment

Meeting the complex health care needs of a rapidly growing, aging and culturally diverse population - like that of Central West LHIN - requires evidence-informed, local planning. It also requires an ability to address broader provincial priorities.

The LHIN's strategic directions and initiatives - outlined in IHSP 2016-2019 and operationalized in ABP 2017/18 - are rooted in the common vision of Ontario's *Patients First*: Action Plan for Health Care, *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario, *Patients First*: A Roadmap to Strengthen Home and Community Care and the objectives of Ontario's 14 LHINs. Committed to meeting provincial priorities identified in the Minister Mandate Letter, ABP 2017/18 focusses on specific activities the LHIN will undertake to advance each of its four strategic directions: *Build Integrated Networks of Care, Drive Quality and Value, Connect and Inform, and Demonstrate System Leadership.*

ABP 2017/18 is the Central West LHIN's work plan for fiscal year April 1, 2017 through to March 31, 2018. It identifies activities that will support the work to be accomplished during the second year of IHSP 2016-2019. In support of the Patients First Act, it also takes into account those activities designed to specifically guide the LHIN through a period of exciting and transformative change.



ACCESS | Improve Access... Provide faster access to the right care.

CONNECT | Connect Service... Deliver better coordinated and integrated care in the community, closer to home.

INFORM | Support people and patients... Provide the education, information and transparency they need to make the right decisions about their health.

PROTECT | Protect our universal public health care system... Make evidence based decisions on value and quality, to sustain the system for generations to come.

Build Integrated Networks of Care

Drive Quality and Value

Connect and Inform

Demonstrate System Leadership

The success of ABP 2017/18 will be documented in the Central West LHIN's 2017/18 Annual Report, which looks back on work accomplished to chronicle how the LHIN's activities placed patients first and ensuring the needs of LHIN residents remained at the centre of their local health care system.

The Central West LHIN Landscape

Population Profile

The Central West LHIN has grown substantially over the past decade, from 740,000 residents in 2006 to over 922,000 in 2015. Central West LHIN residents now account for seven percent of Ontario's population. Furthermore, with the highest projected growth rate in the province – over 17,000 new residents each year – the LHIN's population is expected to grow to almost 1.1 million by 2025. Not only is the Central West LHIN's population growing, it is aging. By 2025, the population of seniors (those aged 65 or more) is expected to increase by 62%, from 111,000 to 180,000.

As one of the most geographically and ethnically diverse LHINs in the province, 86% of LHIN residents reside in urban areas, 8% in a suburban setting, and 6% in rural communities. Forty-seven percent of residents of the LHIN are immigrants – seven percent of whom are new to Canada within five years. Slightly over half of all LHIN residents report English as their mother tongue, the second lowest rate in the province, and 4% of residents report no knowledge of English or French. The LHIN is also home to over 14,000 francophone residents and 5,600 residents who self-report as indigenous people.

Over the past five years, notable investments have improved access to a variety of health care programs and services in the LHIN. In collaboration with HSPs and community partners, the LHIN remains committed to the planning, development and delivery of innovative and creative health care programs and services that meet the current and future needs of LHIN communities.

Health Profile and Access to Care

Timely and appropriate access to primary health care is a key objective of Ontario's *Patients First:* Action Plan for Health Care and IHSP 2016-2019. While almost all (94%) of LHIN residents report having a regular primary care provider, only 58% report the ability to see a primary care provider on the same or next day when sick. These indicators are particularly important for the Central West LHIN's population given the prevalence of certain chronic conditions and premature mortality.

The Central West LHIN has the highest rates of diabetes amongst all the LHINs with a prevalence rate in 2015 of 15.5%. The prevention and management of diabetes will continue to remain a local priority given the unique blend of an unprecedented growth in the seniors population combined with higher proportions of high risk ethnic groups residing within the Central West LHIN.

Many chronic conditions can be prevented or their onset delayed. Smoking, misuse of alcohol, excess weight, poor diet and physical inactivity are well established modifiable risk factors for many chronic conditions. The Central West LHIN has the lowest percentage of self-reported smokers (11.4%) and the lowest proportion of heavy drinkers (11.2%) in the province. Conversely, the rate of self-reported physical inactivity (55.4%) is the highest in the province, and the percentage of overweight or obese adults (57.3%) exceeds the provincial rate.

In 2015/16, residents in the Central West LHIN made 308,265 visits to emergency departments (EDs) in Ontario, an increase of 25% over 2010/11. Most of these visits (71%) were to one of the three EDs within the Central West LHIN. At the same time, there were a total of 258,337 ED visits to Central West LHIN hospitals, an increase of 24% since 2010/11. Brampton Civic Hospital had the busiest ED in Ontario in 2015/16 with 12% more visits than the next busiest ED (137,830 visits, as compared to 123,134 at Humber River Wilson Site). That stated, hospitals in the Central West LHIN had the lowest rate of visits best treated in alternative primary care settings (a 27% reduction since 2010/11), meaning that the very high number of ED visits are appropriate. ED length of stay for patients discharged home from EDs in the Central West LHIN consistently meets provincial targets. However, length of stay for patients requiring admission to an inpatient bed is substantially higher than target, suggesting a need for greater inpatient capacity.

Health Care Resources and Their Use

Over the past five years a 21% increase in base funding, totalling $156 million (from $727 million in 2009/10 to $884 million in 2015/16), has resulted in improved access to a variety of health care programs and services in the Central West LHIN.

Through a budget of $884 million, provided by the MOHLTC, the LHIN funds HSPs and community partners in the regions of Brampton, Caledon, Dufferin County, Malton, North Etobicoke and West Woodbridge.

- 2 hospital corporations across four sites... attending over 70,000 hospital admissions and over 258,300 emergency department visits/year
- 1 Community Care Access Centre (CCAC)... serving over 32,500 clients/year
- 23 Long-Term Care Homes (LTC)... providing an estimated 750,000 resident days/year
- 2 Community Health Centers (CHC) across 5 locations... delivering over 25,000 primary care visits/year
- 15 Community Support Service (CSS) agencies... offering services to over 40,000 clients/year
- 8 mental health and addictions organizations... providing over 20,000 interactions to local LHIN residents /year.

	$ 2009/10	$ 2016/17	$ Increase	% Increase
CCAC	77,593,209	123,234,690	45,641,481	59
Community Health Centres	6,668,770	12,639,799	5,971,029	90
Community Support Services (*incl. Assisted Living*)	11,523,426	26,700,133	15,176,707	132
Hospitals	465,884,631	563,909,726	98,025,095	21
Long-Term Care	136,059,183	160,057,019	23,997,836	18
Mental Health and Addicitons	30,647,492	39,854,730	9,207,238	24
Total ($ in millions)	727,403,702	926,396,097	198,992,395	27

In 2014/15, guided by recommendations contained in Dr. Samir Sinha's *Living Longer, Living Well* report, the LHIN undertook a comprehensive, long-term community capacity study of services for seniors. The community health services capacity plan identified service gaps, challenges within the system, and opportunities for directing investments to better meet the needs of a growing and ageing population.

In 2013/14, there were 2,500 admissions to adult designated mental health units in hospitals within the LHIN. Patients discharged from these beds experienced an average length of stay of 11 days, as compared to 28 days for Ontario. Residents of the Central West LHIN had lower rates of active cases, admissions, discharges and lengths of stay compared with the province.

In 2015/16, early psychosis intervention and support within housing had the longest median wait times among community mental health services provided in Central West LHIN. The median wait times for Central West case management, counselling and treatment, diversion and court support, early psychosis intervention, and support within housing were all greater than provincial values.

Hospitals in the Central West LHIN had the shortest average provincial acute and total length of stay results in 2015/16. In 2015/16, average length of stay for alternate level of care (ALC) was 11 days - the shortest in the province - and the Central West LHIN had the lowest ALC rate (inpatient capacity lost to ALC) of the 14 LHINs. The Central West CCAC consistently performed well in meeting 5-day guarantees for nursing services, and has among the lowest wait times for services in the community. These measures suggest hospital and community resources in the Central West LHIN are being managed efficiently.

In 2013/14, the Central West LHIN had the lowest rates for nursing visits, case management visits and total visit rate per 1000 population in the province, but utilization of home care services has increased over the past three years. The number of home care clients in the Central West LHIN has increased - the active client caseload has increased by 15%, visits have increased by 15%, and home care hours have increased by 51%. As the need for these services continues to grow, the LHIN must continue to invest in capacity of home care services that will be required to meet future demand.

New methods of health care funding continue to be used across the province. These funding models consider growth, population rates and needs across the LHIN, ensuring funding is directed to areas where care is needed most. The Central West LHIN will continue to work with the MOHLTC to implement health care funding reforms that allocate provincial resources in an equitable manner, recognize the growth and needs of the LHIN population, and improve capacity to deliver services for local residents.

French Language Services

The Central West LHIN is home to a vibrant community of over 14,000 francophone residents looking for better access to health care services in French.

With a shared commitment to engage and better understand the needs of the Francophone population, and a want to incorporate a French Language Services (FLS) lens across strategic initiatives, the LHIN is pleased to have a strong and collaborative relationship with Reflet Salvéo, the French Language Health Planning Entity.

To this end, the Central West LHIN is also working with local health care system partners through its FLS Core Action Group (CAG), to which Reflet Salvéo is participating member. More specifically, in collaboration with the FLS CAG, the LHIN and Reflet Salvéo have developed a French Language Services Joint Action Plan to help address the needs and concerns of the local Francophone community. The action plan has identified the following areas of priority:

- Increase Active Offer of French Language Services
- Enhance the mental health status of Francophone newcomers
- Promote equity
- Support the integration of a Francophone lens in system planning activities.

The Joint Action Plan speaks to the need to account for how the LHIN will be taking on the responsibility for the provision of home and community care, and specifically how to ensure that the services are available in French in accordance with the FLS Act. Beginning with a thorough analysis of the process for coordination of French-language home and community care services, the LHIN and its partners commit to acting on subsequent recommendations for improvement to ensure provision of an Active Offer.

In order to deliver on the Joint Action Plan priority of increasing Active Offer of French Language Services, the LHIN must first increase the FLS capacity of HSPs by supporting them through training on Active Offer and assessing the supply and demand of French Language speaking Health Human Resources at a sub-region level.

Identified HSPs have submitted their Designation Readiness Assessment Tools and Plans for providing services in French and Active Offer. The LHIN will evaluate their readiness in 2017/18, working with each HSP to help prioritize actions and create a roadmap to designation (full or partial). The LHIN will also continue to evaluate each HSP's annual FLS report required by their Service Accountability Agreement and is intending to integrate FLS performance indicators into new accountability agreements with HSPs, or when revising existing ones.

Indigenous Peoples

As part of the Provincial Indigenous Leads Network (PILN), the Central West LHIN is committed to engaging Indigenous communities to ensure the local health care system understands and is responsive to their unique needs; from wellness to mental health, chronic disease management

and palliative care. This includes working with local HSPs to ensure Indigenous residents receive culturally competent care; care that recognizes and is tailored to a group's particular social, cultural and linguistic needs. This work will align local health care programs and services with existing regional, provincial and federal health planning, health programming and service delivery systems, designed to ensure better heath and healthier outcomes.

In partnership with the Mississauga Halton LHIN, Central West LHIN is actively engaged with key Indigenous partners including the Credit River Metis Council, Peel Aboriginal Network, Dufferin County Cultural Centre and Métis Nation of Ontario/Health and Wellness in Brampton.

A key deliverable for 2017/18 is the implementation of an Indigenous Advisory Circle (IAC). Through consultation with Indigenous community groups and their respective Leaders/Elders, the Terms of Reference for the IAC have already been drafted. Launch of the IAC provides an important opportunity for the ongoing engagement of Indigenous communities across the LHIN, promoting a common understanding and ensuring the consistent delivery of culturally competent health care programs and services, tailored to particular social, cultural and linguistic needs.

The Central West LHIN has also participated in a Needs Assessment Engagement, held under the leadership of the Dufferin Region First Nations Métis and Inuit (FNMI). This engagement provided the LHIN with an opportunity to obtain a solid understanding about Indigenous peoples; their needs, challenges, social service goals, and gaps in terms of healing and wellness, reconciliation, community building, education, youth programming/activities. The outcome of this Assessment will help the LHIN to further understand and identify where and how to collaborate, partner and strengthen relationships with local Indigenous Peoples.

The Central West LHIN will also continue to support local HSPs and partners in their want to complete the Indigenous Cultural Safety training program. To date, over 150 staff from partner organizations have completed the training.

Through ongoing implementation of the *Patients First*: Action Plan for Health Care, and in collaboration with key Indigenous Leaders/Elders and stakeholders, the Central West LHIN will be able to:

- Build stronger relationships with members of Indigenous communities, in collaboration with Mississauga Halton LHIN, to guide future engagement activities between the LHIN and Indigenous peoples
- Gain a better understanding of Indigenous peoples, programs and gaps in Indigenous health services
- Engage Indigenous organizations and communities to ensure their voices are included in health care planning across the continuum of care
- Receive input from the IAC on a variety of topics including opportunities to improve the delivery of health services in their communities.

Local Opportunities, Risks & Drivers of System Change

Patients First Act and LHIN Renewal

The upcoming year brings with it exciting opportunities to strengthen health care at provincial and local levels. Passed on December 7, 2016, the Patients First Act (2016) is a driver of system change to transform Ontario's health care system. Through implementation of the Patients First

Act, LHINs will be a single regional point of integration and accountability for Ontario's health care system.

As a result LHINs will have an expanded mandate. The objectives that will be accomplished through LHIN renewal and health care transformation include structural changes that will see a better integration of health care services and, over time, patients will experience more efficient and effective care, resulting in a better experience for both patients and those who care for them.

Goals of Patients First: Action Plan for Health Care

More Effective Service Integration, Greater Equity

- Care delivered based on community needs
- Appropriate care options enhanced within communities
- Easier access to a range of care services
- Better connections between care providers in offices, clinics, home and hospital

Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

- All patients who want a primary care provider have one
- More same-day, next-day, after-hours and weekend care
- Lower rates of hospital readmissions; lower emergency department use
- Higher patient satisfaction

More Consistent and Accessible Home and Community Care

- Easier transitions from acute, primary and home and community care and long-term care
- Clear standards for home and community care
- Greater consistency and transparency around the province
- Better patient and caregiver experience

Stronger Links Between Population & Public Health and other Health Services

- Health service delivery better reflects population needs
- Public health and health service delivery better integrated
- Social determinants of health and health equity incorporated into care planning
- Stronger linkages between disease prevention, health promotion and care

Services that Address Needs of Indigenous People Across Ontario

- Strong Indigenous voices in system planning and service delivery
- Better health outcomes for Indigenous peoples
- Social determinants of health unique to Indigenous populations is incorporated into care planning
- Culturally competent care delivery, incorporating traditional approaches to healing and wellness

In support of the Patients First Act, the Central West LHIN and Central West CCAC transitioned to the new LHIN organization on May 31, 2017. Throughout the past year, significant focus was placed on ensuring a seamless transition, invisible to patients and their families. Equally important going forward will be to ensure that transformation activities are equally seamless for patients. Our top priorities in the months include:

- Implementing strategies to improve timely access to home and community care
- Identifying and implementing opportunities to:
  - Strengthen the integration of primary care and home and community care, including options for strengthening linkages between care coordinators and primary care practices
  - Enhance the continuity of care by geographically aligning home care service providers with sub-region boundaries
  - Improve transitions in care, particularly transitions supported by home care

Build Integrated Networks of Care

PRIORITY DESCRIPTION

Ensuring residents have timely access to high-quality, patient-centred care is central to the LHIN's mission. Accordingly, the Central West LHIN remains committed to providing improved access to the right care, at the right time, and in the right place.

This means better integration of existing resources into strong networks of care, investing in areas that require additional capacity to meet the needs of a rapidly growing and ageing population, and looking for new and innovative ways to deliver care more effectively, efficiently and suitably to the needs of geographically and ethnically diverse communities.

CURRENT STATUS

Primary Care and Health Links

The Central West LHIN continues to work with Family Health Teams (FHTs), Community Health Centres (CHCs) and primary care practitioners practicing in other models of organized care, to ensure residents have timely access to multi-disciplinary primary care, provided in appropriate settings as close to home as possible.

Approximately 607 family physicians provide care throughout the Central West LHIN. Residents have access to six FHTs, two CHCs, 33 Family Health Groups (FHGs), 13 Family Health Organizations (FHOs) and over 180 individual fee-for-service practitioners.

Attachment to a primary care physician is high, with 94% of residents of the Central West LHIN reporting they had a regular family doctor in 2015/16. While most residents report having a family doctor, only 58% of residents reported that they could see their primary care provider on the same or next day when sick.

The LHIN is working with providers to develop systems and processes that will reduce or delay avoidable visits to emergency departments (EDs), admission to hospital inpatient units and applications to Long-Term Care. As a result, residents do not appear to be turning to local EDs for conditions that should be manageable within the community. The three EDs in the Central West LHIN have lower proportions of low acuity visits compared to the province as a whole (Canadian Triage and Acuity Scale (CTAS) IV/V: 17% vs. 32%) and the lowest rate of ED visits among the 14 LHINs for conditions such as conjunctivitis, cystitis, otitis media and upper respiratory infections, that could be treated in alternative primary care settings (4.9 per 1,000 population aged 1-74 years in 2015/16).

Through the leadership of the Primary Care LHIN Lead, the Central West Primary Care Network continues to provide a collaborative partnership for initiatives such as Health Links within five sub-regions. This is of particular importance in light of Patients First Act, and as the Central West LHIN will continue to spread the Health Links approach to care coordination within the sub-regions. All of this work is contingent upon the continued development of collaborative leadership and partnerships with local primary care practitioners.

Services for Seniors

Over the past year, progress has continued with respect to the development of a comprehensive continuum of services for seniors. Permanent funding for adult day program expansion was achieved in early 2017 and an analysis of assisted living programs is now underway with the goal of standardizing programs across the LHIN.

The LHIN continues to work closely with the Region of Peel on the development of a Program for All-inclusive Care for the Elderly (PACE). The first of the seven eligible Long-Term Care Homes is proceeding towards construction in accordance with the ministry's Enhanced Long-Term Care Home Renewal Strategy.

Also in early 2017, the LHIN was able to increase investment in the Behaviour Supports Ontario (BSO) program, further supporting seniors who exhibit responsive behaviours and their caregivers. This funding will provide the foundation for the roll out of the provincial Dementia Strategy.

Mental Health and Addictions

The Central West LHIN funds eight Mental Health and Addictions organizations including seven community-based providers and an acute care facility operating two sites, both with inpatient units and outpatient clinics.

In fiscal year 2015/16, these organizations collectively delivered services to over 20,000 unique individuals. Over 12,500 additional individuals received service, but did not share sufficient information to be identified. Services range in function, intensity and duration, and include short and long-term case management, crisis response, counselling and treatment, early intervention, support within housing, residential withdrawal management, diversion and court support, social rehabilitation/recreation, health promotion, and employment support. Given the variability along the continuum of services, the average number of visits range from 3 to 60 per client.

Palliative Care

Aligned with the Ontario Palliative Care Network, a restructured Central West Palliative Care Network (CWPCN) is now in place and continues to enhance capacity for palliative care services in the home and in the community.

CWPCN continues with its foundational work of creating work plans and enabling work groups to deliver on priorities in its Strategic Plan. Key priorities are aligned with the Declaration Document, which was produced by a panel consisting of MOHLTC, LHIN, and HSP representatives to guide the development of palliative care programs within Ontario's 14 LHINs. These priorities include broadening and increasing timely access, strengthening caregiver supports, strengthening service capacity and human resources in all care settings, improving integration and continuity across care settings, strengthening accountability and introducing mechanisms for shared accountability and building public awareness.

Over the past year, the CWPCN has...

- Delivered 5 offerings of the Learning Essential Approaches to Palliative Care (LEAP) courses
- Successfully hosted the Annual CWPCN Conference, attended by over 300 people from across the province
- Established a CWPCN Leadership Team including the recruitment of 2 Regional Clinical Co-Leads
- Established a Central West Governance Structure including a Secretariat, Executive Committee and Operational Leadership Committee
- Completed a Regional Capacity Assessment Survey.

A highlight for the CWPCN was its recent win at the Central West LHIN 2017 Inaugural Quality Awards, for its Early Identification of Palliative Patients project. This initiative resulted in 398 patients identified with a 40% decrease in admission/readmission to hospital, and a 19% decrease in patient dying in the hospital. This work was also presented at the CWPCN Conference, Quality Improvement and Patient Safety Forum, co-hosted with Health Quality Ontario (HQO).

Home and Community Care

Home and Community Care in the Central West LHIN is delivered by 22 unique service provider organizations. This experienced group of providers support a plethora of community health needs across the Central West LHIN. All home and community care providers participate in local health and integration planning in order to improve the health care within this region. Over the past several years, these service provider organizations have been engaged in the examination of population needs at a sub-region level due to the success of a Health Links philosophy of care. This foundation of care delivery and care planning sets the Central West LHIN and its community in a strong position to improve the health care experience at a sub-region level.

Over the past two years the Central West Community Care Access Centre has moved to a neighbourhood model of care that was implemented to support integration with primary care providers and other community providers in order to provide outstanding, collaborative care coordination and system navigation services in partnership with the community served and other health service providers. The neighbourhoods are defined by the Central West LHIN sub-regions.

Each primary care provider in the Central West LHIN is aligned with one Care Coordinator. Care Coordinators connect on a regular basis with primary care practices to participate in inter-professional rounds, consult with

physicians, engage physicians in care plan development and/or come alongside physicians in problem-solving regarding the most complex patients on their caseload. In addition to supporting the alignment of Care Coordinators to Primary Care physicians and Nurse Practitioners, the neighbourhood model of care allows Care Coordinators to develop more knowledgeable and intimate relationships with the community services and other supports.

GOAL STATEMENT

The Central West LHIN will...

- Deliver effective integration of services and greater equity through sub-region planning
- Implement more consistent and accessible home and community care
- Increase timely access to and better integration of primary care and specialists

CONSISTENCY WITH GOVERNMENT PRIORITIES

ABP 2017/18 aligns with government priorities in so far as...

Primary Care and Health Links

Ontario's *Patients First*: Action Plan for Health Care identifies timely access to primary care and improved transitions among providers as being key components toward ensuring the needs of patients remain at the centre their health care system.

The Patients First Act identifies the requirement of each LHIN to identify a clinical lead within each sub-region. The focus of this leadership role will be to enhance access to primary care and seamless coordination of care between primary care and other services. In Central West, our Health Link regions align to our sub-region boundaries and this will create enhanced opportunities for providers and patients to interact and provide valuable input into sub-region planning.

Through the collaborative work of Health Links, FHTs, CHCs, home and community care and the Primary Care Network, patients will receive faster care, spend less time waiting for services, and will be supported by a team of providers across the health care system.

Building upon the foundation of Health Links, the formation of sub-region collaboratives will create a formal space for the development and implementation of innovative solutions to the unique challenges and opportunities faced by the local population. Members of the Collaborative will actively lead and participate in the integration of services with the goal of improving the overall care experience and health outcomes for the patients, clients and their families within the sub-region. For the first year, each of the five sub-regions will share the common objectives of improved system transitions, improved access to community mental health and addictions services and improved palliative care services. While the common objectives are shared amongst the five sub-regions, the specific action item and initiatives will be unique and tailored to the individual sub-region. Fostering local innovations will ultimately lead to health care solutions that are better able to accommodate the socio-cultural needs of the local population.

Mental Health and Addictions

Mental Health and Addictions initiatives underway and/or being pursued by the Central West LHIN align with:

- Ontario's *Patients First:* Action Plan for Health Care
- *Open Minds, Healthy Minds*: Ontario's Comprehensive Mental Health and Addictions Strategy

- Ontario's Opioid Strategy
- *Moving on Mental Health:* A system that makes sense for children and youth.

Through early identification and intervention, and enhanced community-based services, the LHIN is working to ensure that residents with mental health conditions and addictions receive timely access to the most appropriate services as close to home as possible. The LHIN, in collaboration with other LHINs, is also committed to advancing the work of the Provincial Leadership Advisory Council as approved by the Minister of Health and Long-Term Care, and improving service quality as guided by Health Quality Ontario.

The Central West LHIN's action plans are aligned with desired provincial outcomes to ensure:

- More people find stable housing
- More people are identified and served through integrated primary care and community services
- Less people rely on emergency departments
- Improved transitions of youth to the adult system, possibly supported by an Integrated Youth Service hub
- More people receive evidence-based programing.

Palliative Care

Since 2011, the development of palliative care programs within Ontario's 14 LHINs has been guided by the *Declaration Document*. In addition to the Declaration Document, as one of its 10 steps to improving home and community care, Ontario's *Patients First*: A Roadmap to Strengthen Home and Community Care calls for greater choice in palliative and end-of-life care. The MOHLTC has also cited the need for expanded access and equity, and new supports for caregivers.

The LHIN will leverage opportunities outlined in *Patients First*: A Proposal to Strengthen Patient-Centred Health Care in Ontario, to plan for better palliative and end-of-life care using a sub-region population-based approach.

Home and Community Care Renewal

Home Care Renewal in the Central West LHIN will focus on initiatives that ensure patients consistently receive integrated, accessible and high quality care. The LHIN will continue to strengthen the alignment of care coordination with primary and specialty care in order to ensure timely access to home and community care support as described in the *Patients First*: Action Plan for Health Care. Likewise, Health Links Resource Coordinators are already embedded in primary care locations serving a system navigation role and will be supporting our sub-region clinical leads and sub-region work.

Action Plans/Interventions[1]	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Building on Health Links as a foundation for sub-region planning, expand the scope and scale of Health Links as an approach to sub-region collaboration.	In progress	50	Ongoing	25	Ongoing	25
Recruit a Clinical lead for each sub-region.	Not yet started	100				

Complete a Primary Care Capacity Assessment and develop a plan for each sub-region to address gaps and improve access.	In progress	50	Ongoing	25	Ongoing	25
Home and Community Care Renewal planning that supports consistency in care delivery through transition and in the implementation of new models of care.	In progress	50	Ongoing	25	Ongoing	25
Strengthen consistency in Care Coordination across the Central West LHIN to support primary care integration and population health priorities at the sub-region level.	Not yet started	25	Ongoing	50	Ongoing	25
Enhance local mental health and substance abuse services per provincial strategies and standards, addressing ongoing gaps and emerging issues including supportive housing, integrating primary care, opioid addiction and structured psychotherapy.	In progress	20	In progress	30	In progress	20
Implement the work plans for year 1 of the Strategic Plan for the Central West Palliative Care Network, including an education campaign to spread the "Pledge".	Not yet started	25		50		25
Improve access and referrals to Specialty Care through the implementation of enabling technologies such as, but not limited to, eConsult and eReferral.	In progress	40	In progress	40	Ongoing	20
Develop a comprehensive continuum of care option for seniors at the sub-region level, including adequate primary care, home care, adult day programs, assisted living options, transportation, hospital, palliative and PACE.	In progress	33	Ongoing	33	Ongoing	34
Develop a comprehensive, electronically-enabled system access model.	In progress	30	In progress	30	Ongoing	10

How will the LHIN measure success?

Within and across the five sub-regions, more residents will have access to after-hours care, same-day or next-day appointments and fewer individuals will require care in hospitals for conditions that are better managed in primary care settings.

- Spread and scale the Health Links approach and reach a target of 10,000 coordinated care plans.
- Through care coordination and Health Links, reduce the proportion of identified complex patients accessing emergency department and inpatient acute care services by 25%.
- Implementation of 5 sub-region collaboratives or planning tables.
- Recruitment of a Clinical lead for each sub-region.
- Increase the number of primary care providers utilizing eConsult from 55 to 120.
- Increase the number of Central West LHIN based specialists utilizing eConsult from 8 to 50, specifically in the areas of Internal Medicine, Psychiatry, Palliative Care, Geriatrics and Dermatology
- Maintain current quarterly performance on avoidable emergency department visits for conjunctivitis, cystitis, otitis media and upper respiratory infections (< 1.5 visits per 1,000 population aged 1-74 years).

- Maintain the rate of readmissions within 30-days of discharge for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes diagnoses at less than the expected rate.
- PACE or enhanced seniors model is designed and piloted in one sub-region.
- System access model is developed electronically and successfully piloted in a sub-region.

Enhanced mental health and addiction services

- Increase the number of supportive housing units by 20%.
- Increased collaboration, care coordination and referral networks between primary care and community providers.
- Opioid Support Services: Central West collaborates with the LHIN to complete an addictions services strategy.

Streamlined Palliative Care services

- Increase the proportion of palliative care patients who die in their place of choice by 5%
- Show a 5% increase the percentage of palliative care patients identified early in their continuum
- Ensure that all palliative care patients have a coordinated care plan

Strengthened care coordination integration across the Central West LHIN

- Increase in number of Health Links care planning with primary care
- Increase in number of primary care case conferences in the support of patient care

Risks/Barriers to Successful Implementation	
Risk	**Mitigation Strategy**
Complexity of the relationship between provincial primary care associations and provincial health care planning influences local partnerships.	▪ The Central West LHIN will continue to work with the Ministry of Health and Long-Term Care (MOHLTC) and member based organizations such as the Ontario Medical Association (OMA) and Ontario College of Family Physicians (OCFP), and sub-region Clinical Leads to support local physician championship of programs and service enhancements. ▪ The Central West LHIN will implement a managed implementation plan for renewal based on readiness of primary care leadership and remaining committed to physician collaboration and co-designed outcomes.
Year-over-year population growth will enhance structural deficits related to physician supply in the Central West LHIN and associated sub-regions, increase pressure on the availability of and access to local family physicians for residents.	▪ Enhance the use and monitoring of referral patterns to primary care through Health Care Connect. ▪ Monitor physician supply, recruitment and model adoption through the LHIN's Health Force Ontario Community Partnership Coordinator. ▪ Monitor referral patterns to Health Links for barriers to access and growth in demand.
With the highest projected growth rate in the province, the seniors population in Central West LHIN is projected to grow by 62% by 2025. Caring for this growing population in the community will continue to be a challenge as acuity levels climb.	▪ Central West LHIN must continuously expand and improve the quality of community-based services for seniors and their caregivers through continued funding support and integration opportunities

Growth in Supportive Housing requires the alignment of respective resources and an integrated approach amongst the Central West LHIN, four municipal services managers, and the ministries of Health and Long-Term Care and Housing.	▪ Continued participation with municipal services managers to co-deliver on Housing and Homelessness Plans and the 10-year Mental Health and Addictions strategy. ▪ Participation in provincial housing initiatives including pan-LHIN work plans. ▪ Prioritize Supportive Housing for investment when aligned with partners' resources.
Developing an addictions services strategy requires a cross-sector team i.e. mental health, addictions, primary care, to not only envision the strategy but to deliver on it.	▪ Consolidate an engagement plan with the primary care lead to ensure priorities are set across all initiatives and an effective plan is in place. ▪ Work through the existing structure of the Narcotics Strategy partnership to incorporate this deliverable to their work plan.
The scale of the initiative and the transformative change inherent in establishing a system access model will require efficient and effective oversight and resource management to operationalize it.	▪ Allocate project management resources to the initiative. ▪ Conduct consistent collective and separate engagement with stakeholders across care pathways including to finalize a project charter. ▪ Identify and understand risks and ensure stakeholder agreement on those that can be mitigated, accepted, transferred or deferred.
Year-over-year population growth will enhance structural deficits related to home and community care demand could produce gaps in service and dedication of care coordinator resources to primary care partners.	▪ Sub region planning to determine priority setting of developmental support required in order to strengthen consistency and quality of partnered relationship between primary care and care coordination functions. ▪ Develop an in depth analysis of care coordination resources across the LHIN.
The complexity and sheer volume of stakeholders and partners required to provide the full continuum of palliative care services leads to gaps in service and fractured communication channels.	▪ Strong stakeholder relationship management strategy including the utilization of the CW PCN Governance structure; Executive Committee, Operational Leadership Committee and Work Groups.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2019/20.

KEY ENABLERS

- Continued support, implementation and sustainment of digital health solutions aligned with the provincial digital health priorities for 2017/18 is required to support the building of integrated networks of care.
- Implementation of eConsult, eReferral, eVisits, Connecting Ontario, Ontario Lab Information System, Telehomecare and the usage of telemedicine and care coordination solutions must continue in 2017/18 in order to support the goals of building integrated networks of care.

- Establishing a comprehensive access model will require robust stakeholder engagement. It will also require a shared vision for the benefits that streamlined access and coordinated care will have on the patient/client.
- Use of the business process and implementation plan, developed within the mental health and addictions sector, will enable the benefits of centralized access.
- Integration of technology will help to enable the gathering and retention of anonymized, easily accessible data for improved service planning.
- Expansion of Supportive Housing will require the provision of safe, affordable housing, coupled with rent supplements to ensure affordability and support services.
- Cross-sector collaboration with provincial and municipal agencies/ministries including health and housing and municipal service managers responsible for housing and homelessness
- LHIN must enable outreach to private landlords by housing providers.
- Coordination across LHINs will ensure efficient and effective partnerships with municipal service managers in the Greater-Toronto Area. Mapping has been done with the aim to identify LHIN Leads for each municipality where planning affects residents in multiple LHINs.

Drive Quality and Value

PRIORITY DESCRIPTION

Enhancing the patient experience of care is recognized as being a major deliverable in achieving a high-quality, high performing, and value-driven health care system, aligned with the objectives of Ontario's *Patients First:* Action Plan for Health Care. To this end, the Central West LHIN is committed to continuously improving the health and health status of our residents by strengthening its accountability and service delivery. This can only be accomplished through effective partnerships with HSPs and other stakeholders, where collaboration on local and provincial quality-focused and evidence-informed initiatives are aligned.

As a primary funder, the Central West LHIN must also support the sustainably of HSPs in a constrained funding environment. Health care decisions have to be evidenced-informed, reflect the patient experience, and must place the needs of patients first. The Central West LHIN is committed to funding and using health care resources in a sustainable, effective, and efficient way that demonstrates quality and value to the community while protecting our universal public health care system.

The *Patients First: Digital Health Strategy* and the provincial digital health priorities for 2017/18 are vital supports to the *Patients First*: Action Plan for Health Care. Information technology (IT) and information management (IM) are key elements that enable the empowerment of patients, and connect their continuum of care. Digital health solutions assist patients, their caregivers, and their Health Service Providers to share information and coordinate services quickly and efficiently as they transition from one care provider to another.

CURRENT STATUS

An essential element of the LHIN's oversight role is to collaborate with HSPs in pursuit of creating and sustaining a culture of quality improvement. Accordingly, the Central West LHIN Board of Directors has endorsed the implementation of a number of initiatives including:

- a Board Quality Committee has been established to provide leadership and oversight for the quality of local health care services, and to advance a culture of quality and its continuous improvement across the local health system.
- adoption of a quality framework that is aligned with Health Quality Ontario's dimensions of quality: safe, effective, patient-centered, efficient, timely and equitable health care.
- establishment of regular governance-to-governance visits to HSPs, engaging in discussions focused on provider quality initiatives, and challenges and opportunities that inform further collaborative quality improvement initiatives.
- a Clinical Quality Lead, in collaboration with HQO, has been appointed to support the creation of a culture of quality amongst HSPs. This culture of quality will demonstrate improved patient outcomes, experience of care and value for money.
- a Regional Quality Table (RQT) has been established that provides the necessary structure to align local, regional and provincial quality priorities and initiatives. Made up of representation from across the LHIN including sub-regions and sectors, the RQT is developing an integrated, regional quality plan for implementation in 2017/18. Through engagement of key internal and external partners and providers, the quality plan will promote enhanced integration and collaboration to achieve measureable improvements in system access and performance across the Central West LHIN. The RQT is also examining available data, measures and best evidence-based models of care to determine areas of focus for their work over the next fiscal year. Reviews of data demonstrate significant variation in patient management and/or treatment for specific diseases across LHINs. Opportunities to decrease unwarranted variation exist not only provincially but locally through the introduction and adoption of Quality Standards. Ontario's *Patients First:* Action Plan for Health Care.
- an HSP Quality Leaders' Forum has been established. Membership consists of quality improvement leaders from all sectors across the LHIN with a mandate focused on system-wide quality improvement and change management strategies to support enhanced health care outcomes and experiences for people and patients.
- selection of three system-level quality aims, through a consultative process with HSPs, that include improved system navigation, access to Mental Health and Addictions services, and an improved patient experience. These priority areas are considered as proxy indicators to demonstrate system performance along the continuum.

GOAL STATEMENT

Throughout the coming year, the Central West LHIN will leverage the following foundational components to realize further quality improvements that support achievement of provincial and local priorities. Specific focus will be placed on:

- development and implementation of an Integrated Regional Quality Plan
- ensuring the voices of patients, caregivers and stakeholders are heard and actively consulted through transformation of the health care system
- continuing to deliver on the LHIN's accountability to monitor and report on progress in achieving local performance targets
- opening up access to health information and services
- strengthening quality effectiveness and accountability
- stimulating innovation and growth.

CONSISTENCY WITH GOVERNMENT PRIORITIES

ABP 2017/18 aligns with government priorities in so far as...

- The local quality agenda is supportive of Heath Quality Ontario's provincial quality mandate, the key objectives of *Patient's First*: Action Plan for Health Care, the transformation agenda and in meeting needs of the local population.
- The work of the RQT in reducing unwarranted variation in patient care management and creating more standardized approaches to treatment are important elements of Ministry strategy. Creation of local implementation strategies to ensure adoption of quality standards is required to ensure patients receive the right care at the right time in the right place. LHIN sub-regions provide an appropriate setting for local accountability with respect to sharing and participating in the application of quality standards in the delivery of care.
- Continuing to ensure digital health priorities are successfully delivered in partnership with provincial digital health delivery organizations including eHealth Ontario, Ontario Telemedicine Network (OTN) and OntarioMD will support timely and coordinated system access for residents of the Central West LHIN.
- The creation of a Patient and Family Advisory Committee is consistent with the MOHLTC's Patients First strategy. It provides an opportunity to understand challenges faced by patients, families and caregivers in navigating and using the local health care system. Using feedback obtained through several mechanisms, improvements can be made that support sustainable change and meet the needs of the local population.
- Capturing the patient voice (and those of caregivers and family members) is an integral component of measuring the patient experience. Partners across the LHIN continue to collect information from patients about their care encounters, while efforts are underway to determine a LHIN-wide approach that brings together local and provincial measurement strategies along transitions in care. At least two Patient and Family Advisory Committees are in place within the LHIN that are leveraged to inform future planning efforts.

Action Plans/Interventions	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Based on best practices and with input from LHIN partners, develop and operationalize a Central West LHIN Patient and Family Advisory Committee.	In progress	100	Ongoing		Ongoing	
Work with clinicians, health service providers and other partners at the regional and sub-region levels to support development and implementation of a regional quality plan.	In progress	20	Ongoing	40	Ongoing	40
Continue to report on progress towards achieving health system performance targets and the success of transformational activities.	In progress	33	Ongoing	33	Ongoing	33
Continue to develop and implement a digital health solutions strategy that enables continued quality enhancements.	In Progress	40	Ongoing	30	Ongoing	30
Continue to support our hospital partners through the implementation of the Hospital to Home (H2H) project and other integrated funding models or innovations	In Progress	30	Ongoing	20	Ongoing	

How will the LHIN measure success?
▪ Metric(s) will be determined once Quality Standard adoption strategies have been developed among key stakeholders. ▪ Establishment of a Patient and Family Advisory Committee.

Risks/Barriers to Successful Implementation	
Risk	Mitigation Strategy
Lack of provider support for consistent adoption and implementation of Quality Standards that results in ongoing variations in care delivery.	▪ Link adoption of Quality Standards to Accountability Agreements ▪ Regular reporting and monitoring of status of implementations
Misalignment of local and provincial approaches to measuring and monitoring patient experience.	▪ Consultation with MOHLTC and HQO to ensure alignment and avoiding duplication of efforts.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2019/20.

KEY ENABLERS

- Continued support, implementation and sustainment of digital health solutions aligned with the provincial digital health priorities for 2017/18 is required to drive quality and value across the continuum of care.
- Creation of local implementation strategies to ensure adoption of quality standards is required to ensure patients receive the right care at the right time in the right place. LHIN sub-regions provide an appropriate setting for local accountability with respect to sharing and participating in the application of quality standards in the delivery of care.

Connect and Inform

PRIORITY DESCRIPTION

The Central West LHIN is committed to improving the health of the population and reducing health disparities through inclusive, evidence-based and coordinated actions across the continuum of care. As outlined in the Patients First Act, the LHIN will work with Public Health, community and health system partners to develop and implement health promotion strategies that connect, inform and support partners and residents towards better population health outcomes across all sub-regions in the LHIN.

CURRENT STATUS

The Central West LHIN is a rapidly growing, ageing and ethno-culturally diverse community. These characteristics have significant implications for the health of the local population and the health

care system as a whole. When groups or individuals live in social isolation, environments that do not support health, face barriers to access, or receive a lower standard of care, this leads to poorer health, greater strain on limited health care resources, and ultimately higher costs for worse outcomes. Therefore, the LHIN is actively partnering with Public Health, community and health system partners to better connect and inform residents in creating supportive environments that facilitate healthier choices and better utilization of the health care system. As a first step, it is critical for the LHIN and health system partners to understand local context, health disparities, and service needs. Through concerted efforts on data collection, sharing and analysis, the LHIN will assess current service delivery and future planning to create healthier environments and improve access and quality of health care services. This population based planning approach is foundational to sub-region planning.

The LHIN has begun the process of cross-referencing health care utilization data with socio-demographic and health status information at the sub-region level in an effort to identify key disparities, barriers, and priorities moving forward. An early opportunity emerging from such analysis is the LHIN-led Healthy Communities Initiative.

In response to high diabetes prevalence rates, unhealthy built environments and a population with a high genetic predisposition to diabetes, the LHIN is facilitating cross-sector partnerships between Public Health Units, primary care providers, school administrators and other stakeholders to ensure a comprehensive approach to addressing a health disparity and promoting population health.

GOAL STATEMENT

The Central West LHIN will...

- Utilize an evidence-informed, population health approach to sub-region planning.
- Create stronger ties to Public Health through a population health approach.

CONSISTENCY WITH GOVERNMENT PRIORITIES

ABP 2017/18 aligns with government priorities in so far as...

MOHLTC and LHINs have a legal and ethical responsibility to integrate equity considerations into planning and decision making. These have been outlined in the Canada Health Act, Future of Medicare Act, Charter of Rights and Freedoms, the Ontario Human Rights Code and most recently, the Patients First Act, 2016.

While most of the levers for the social determinants of health lie outside the purview of the MOHLTC and LHINs, this presents an opportunity for greater collaborations between the health care system and other population health focussed organizations that can better meet the needs of populations at risk for poor health. Addressing health equity has also been noted as making critical contribution to health system sustainability by reducing the incidence of costly and preventable illnesses and related treatments.

Action Plans/Interventions[1]	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Partner with Public Health Units and community organizations to develop sub-region population health profiles based upon available datasets and unique sub-populations.	In progress	100				
Through the Healthy Communities initiative in the Central West LHIN, bring together health and social services to broaden perspective for action based on the social determinants of health.	In progress	30		30		30

How will the LHIN measure success?

- Population Health Profiles created for each of the five sub-regions to support planning and performance monitoring.
- Number of health promoting environmental and policy changes made amongst partner agencies involved in the Healthy Communities Initiative.
- Self-reported increases in physical activity and improved healthy eating decisions amongst school aged children involved in the Healthy Communities Initiative.

Risks/Barriers to Successful Implementation

Risk	Mitigation Strategy
▪ Lack of reliable data on the use of health care services by members of specific communities limits local knowledge of service use among diverse populations.	▪ The Central West LHIN will focus on monitoring and tracking available data that captures residents' access to and use of services by race, culture, language and gender. ▪ Central West LHIN staff will engage with data custodians at different levels of government and across sectors to gain access to data to better understand neighbourhood profiles in order to match services to need.
▪ Service and resource pressures driven by population growth may deflect attention away from specific needs of high-risk communities.	▪ Integrate the health equity lens in sub-region planning to ensure that health disparities are identified and appropriately addressed.

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KEY ENABLERS

- The development of sub-region planning tables or Collaboratives will build on established relationships by inviting cross-sector partners to the table, and will work with provincial organizations such as HQO to embed health equity into planning.
- Strong leadership will also enhance cooperation and engagement amongst the diverse partners and active participation to develop cross sector strategies that improve the social determinants of health for local and regional populations.

Demonstrate System Leadership

PRIORITY DESCRIPTION

The Central West LHIN is responsible for ensuring that the health system delivers the best possible outcomes in terms of population health, value, and the patient experience. To carry out its responsibilities, the LHIN works with its partners to provide system leadership to serve patients, clients and residents. This leadership includes capacity planning, guiding system-wide initiatives, and supporting stakeholders throughout the system to provide the best possible care and outcomes for the population. This leadership also takes place in the context of provincial priorities that increasingly call for collaboration with government and other entities that extend well beyond the health sector.

CURRENT STATUS

The LHIN has established a Diversity and Health Equity CAG comprised of funded providers who advise and inform on effective ways to improve cultural competency and minimize gaps for vulnerable populations.

One of the key ways to increase capacity and integration of health equity approaches is the introduction and utilization of the Ministry-developed Health Equity Impact Assessment (HEIA) tool. The LHIN is actively working with health system partners to gain a current understanding of the effective collection and analysis of sociodemographic data to improve program effectiveness and future planning and improved access and quality of health care services.

At the same time, the LHIN has begun the process of cross-referencing health care utilization data with socio-demographic information at a sub-region level in an effort to identify sources of inequity in the spatial accessibility of health care services.

To ensure accountability in increasing equity in program planning and service delivery, the LHIN continues to review and monitor HSP health equity plans/progress reports. There is also a proactive approach to connect with cross-sector partners such as Public Health Units and local immigration organizations to ensure a comprehensive approach to health equity and population health.

GOAL STATEMENT

The Central West LHIN will...

- Lead the local adoption and spread of high-yield provincial initiatives.
- Complete sub-region capacity plans in the context of provincial capacity planning initiatives.

CONSISTENCY WITH GOVERNMENT PRIORITIES

ABP 2017/18 aligns with government priorities in so far as...

The Ministry's Health Equity Office is actively working with LHINs, HQO and Public Health Ontario to develop approaches that increase health equity in provincial health system planning and delivery.

Addressing health equity has also been noted in the Patient's First Act as well as the September 2016 Premier's Mandate Letter to the Minister of Health, reiterating the importance of incorporating health equity approaches and strategies into future health system planning and delivery.

Action Plans/Interventions[1]	2017/18		2018/19		2019/20	
	Status	%	Status	%	Status	%
Work with system partners to deploy local strategies to improve system flow, lower hospital admission rates and reduce ALC.	In progress	30	Ongoing	30	Ongoing	20
Implement the Levels of Care Framework for Home and Community Care across the Central West LHIN.	Not yet started	60	Ongoing	20	Ongoing	20
Integrate health equity strategies and approaches to population health planning, service delivery and performance improvement.	In progress	40	Ongoing	30	Ongoing	20
Lead the local implementation of the provincial dementia strategy.	Not yet started		Ongoing		Ongoing	
Begin implementation of the plan to enhance access to Musculoskeletal (MSK) services.	Not yet started		Ongoing		Ongoing	

How will the LHIN measure success?

The LHIN will measure the success of integrating health equity by:

- Utilizing sub-region data that includes socio-demographics of the local population to inform system level and health service provider level planning and service delivery
- Monitoring compliance and implementation of health service provider health equity plans and progress reports
- Training all HSPs on the provincially developed Health Equity Impact Assessment Tool (HEIA)
- Increasing cross sector partnerships at the pan-LHIN Health Equity table and the local Diversity and Health Equity Core Action Group
- Integrating health equity approaches in regional programs i.e. Health Links, Telehomecare.

Dementia Strategy

- Monitor admissions to hospital for dementia-related conditions
- Decrease the number of Form 1 admissions to ED from LTC
- Minimize the rate of ALC to LTC designations as a result of responsive behaviours
- Increase the proportion of Health Links plans for people with dementia.

Level of Care Framework Implementation	
▪ All home and community care patients will be categorized under new framework within 9 months of the rollout of the framework. ▪ Stakeholder engagement will result in increased awareness among Central West LHIN residents as to where to access information on available bundles of care. ▪ Information and Referral activities will increase as patients are navigated to the best match of services to their unique needs.	
Risks/Barriers to Successful Implementation	
Risk	**Mitigation Strategy**
Rapid growth in the senior's population outstrips capacity to provide high quality dementia care.	▪ Conduct a capacity plan and update it regularly. ▪ Engage cross-sector partnerships.
Reliable and timely transportation services are needed to support vulnerable people to live at home longer.	▪ Transportation service needs will be integrated into associated care plans for those requiring home and community care services.
Increased numbers of higher acuity people living with dementia being maintained in the community will lead to increased caregiver burnout.	▪ Expansion of planned and emergency respite options.
Year-over-year population growth outstrips available resources	▪ Sub-region population planning to determine care needs in alignment with levels of care. ▪ Partnering with all home and community care health service organizations to increase innovative care models.

[1]Per MOHLTC guidelines, the status of work (Not Yet Started, In Progress, Deferred or Completed) is indicated as a percentage of completion anticipated over the next three years. "Ongoing" refers to work which, while being completed or complete, will continue to various degrees in subsequent years. Percentages may not equal 100% due to work completed in previous fiscal calendar years, or work that is expected to carry forward beyond fiscal year 2018/19.

KEY ENABLERS

The Central West LHIN's provincial and local partnerships and relationships are key to embedding an aligned and consistent approach to integrating health equity strategies. Key partners include MOHLTC, PAN-LHIN Health Equity Collaborative, HEIA Communities of Interest, Health Quality Ontario (HQO), Wellesley Institute, Public Health, Regional Diversity Roundtable (RDR), Peel Newcomer Strategy Group (PNSG) and the LHIN's funded HSPs. These relationships along with cross sector partnerships ensure an inclusive and aligned approach when integrating health equity in system planning and service delivery.

LHIN Operations

Three-Year LHIN Operations Spending Plan

LHIN Operations Spending Plan						
LHIN Operations Sub-Category ($)	**2015/16 Allocation**	**2015/16 Actuals**	**2016/17 Actuals**	**2017/18 Planned Expenses**	**2018/19 Planned Expenses**	**2019/20 Planned Expenses**
Salaries and Wages	2,383,473	2,479,708	2,490,697	2,454,924	2,494,895	2,525,803
EMPLOYEE BENEFITS						
HOOPP	238,347	239,988	249,017	245,491	249,489	252,580
Other Benefits	262,182	277,400	286,150	270,043	273,599	276,999
Total Employee Benefits	***500,529***	***517,388***	***535,167***	***515,534***	***523,088***	***529,579***
TRANSPORTATION AND COMMUNICATION						
Staff Travel	15,000	18,935	17,883	20,000	20,000	20,000
Governance Travel	20,000	10,442	15,771	17,250	18,975	18,975
Communications	75,000	43,681	74,869	51,000	51,000	51,000
Other	-	5,428	26,650	-	-	-
Total Transportation and Communication	***110,000***	***78,486***	***135,173***	***88,250***	***89,975***	***89,975***
SERVICES						
Accommodation	184,000	170,816	202,722	190,046	161,539	161,539
Advertising	20,000	24,470	39,352	16,000	16,000	16,000
Banking	100	99	104	100	100	100
Consulting Fees	253,141	174,467	44,367	80,000	45,457	8,058
Equipment Rentals	8,000	5,063	3,222	7,850	7,850	7,850
Insurance	7,000	5,067	4,911	5,031	5,031	5,031
LSSO Shared Costs*	285,344	283,166	259,858	-	-	-
LHIN Collaborative*	34,141	35,242	23,865	-	-	-
Other Meeting Expenses	20,000	25,296	74,158	40,000	40,000	40,000

Board Chair's Per Diem Expenses	72,800	33,925	41,328	50,929	50,929	50,929
Other Board Members' Per Diem Expenses	92,300	54,089	48,222	104,321	114,753	114,753
Other Governance Costs	30,000	26,219	13,394	33,679	37,047	37,047
Printing and Translation	50,000	35,885	34,627	50,000	50,000	50,000
Staff Development	46,000	50,489	68,117	46,000	46,000	46,000
Total Services	***1,102,826***	***924,293***	***858,247***	***623,956***	***574,706***	***537,307***
IT Equipment	20,000	47,705	43,633	20,000	20,000	20,000
Office Supplies & Purchased Equipment	45,000	59,976	64,695	40,000	40,000	40,000
Total Supplies and Equipment	***65,000***	***107,681***	***108,328***	***60,000***	***60,000***	***60,000***
Capital Expenditures	20,000	-	21,674	10,000	10,000	10,000
LHIN Operations: Total expenditure/allocation	**4,181,828**	**4,107,556**	**4,149,286**	**3,752,664**	**3,752,664**	**3,752,664**
Total CCAC expenditure/allocation	-	-	-	**129,442,066**	**129,442,066**	**129,442,066**
TOTAL LHIN Operations and CCAC expenditure/allocation	**4,181,828**	**4,107,556**	**4,149,286**	**133,194,730**	**133,194,730**	**133,194,730**
TOTAL Annual Funding Target	4,181,828	4,141,828	4,150,023	133,194,730	133,194,730	133,194,730
Surplus	-	34,272	737	-	-	-
* As of March 1, 2017, the LHIN Operations Spending Plan reflects the transfer of LHIN Shared Services Office and LHIN Collaborative funding to Health Shared Services Ontario						
INITIATIVES SPECIFIC FUNDING						
French Language Services	106,000	106,000	106,000	106,000	106,000	106,000
Annual Funding Target	106,000	106,000	106,000	106,000	106,000	106,000
French Language Services Surplus	-	-	-	-	-	-
Diabetes Regional Coordination Centre	856,301	747,855	693,098	839,175	839,175	839,175
Annual Funding Target	856,301	839,175	839,175	839,175	839,175	839,175
Diabetes Regional Coordination Centre Surplus	-	91,320	146,077	-	-	-
Aboriginal Community Engagement	7,500	5,278	7,003	7,500	7,500	7,500
Annual Funding Target	7,500	7,500	7,500	7,500	7,500	7,500
Aboriginal Community Engagement Surplus	-	2,222	497	-	-	-
ER/ALC, Performance Lead	100,000	100,000	100,000	100,000	100,000	100,000
Annual Funding Target	100,000	100,000	100,000	100,000	100,000	100,000
ER/ALC, Performance Lead Surplus	-	-	-	-	-	-

Three-Year LHIN Staffing Plan

Staffing						
Position Title	**2014/15 Allocation FTEs**	**2015/16 Actuals FTEs**	**2016/17 Actuals FTEs**	**2017/18 Forecast FTEs**	**2018/19 Forecast FTEs**	**2019/20 Forecast FTEs**
Chief Executive Officer	1	1	1	1	1	1
Vice President Corporate Services, Accountability & Quality	1	1	1	1	1	1
Vice President Health System Planning, Integration & Strategy	1	1	1	1	1	1
Executive Assistant	2	2	2	2	2	2
Administrative Assistant, Health System Integration	1	1	1	1	1	1
Board and CEO Liaison	1	1	1	1	1	1
Support Analyst	1	1	1	1	1	1
Director, Health System Integration	4	4	4	4	4	4
Director, Funding and Allocation	2	2	2	2	2	2
Director, Performance & Accountability	1	1	1	1	1	1
Quality Lead	1	1	1	1	1	1
Director, Communication and Community Engagement	1	1	1	1	1	1
Director, ER/ALC/Decision Support	1	1	1	1	1	1
Specialist, Performance & Quality	1	1	1	1	1	1
Specialist, Performance, Integration & Quality	1	1	1	2	2	2
Specialist, Decision Support	1	1	1	1	1	1
Health System Performance – Business/Financial Analyst	1	1	1	1	1	1
LHIN Operations Manager	1	1	1	1	1	1
Director, Health System Integration (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Administrative Assistant (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Health System Integration Specialist (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Health System Integration and Quality Improvement Specialist (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
Specialist, Decision Support (Diabetes Regional Coordination Centre) *	1	1	1	1	1	1
French Language Services Coordinator and Indigenous Health Consultant	1	1	1	1	1	1
Total FTEs	**29**	**29**	**29**	**30**	**30**	**30**
Total CCAC FTEs transfer to LHINs	-	-	-	**303**	**303**	**303**
Vice President Home and Community Care	-	-	-	**1**	**1**	**1**
Vice President Clinical	-	-	-	**1**	**1**	**1**
Vice President People Services, Employee Experience & Public Relations	-	-	-	**1**	**1**	**1**
Grand Total	**29**	**29**	**29**	**336**	**336**	**336**

Communications & Community Engagement

Ontario's health care system has evolved to a point where LHINs are recognized for their leadership role in driving local health system transformation.

Through Ontario's *Patients First*: Action Plan for Health Care, the Patients First Act and Minister Mandate Letter the Central West LHIN has a critical role to play in moving provincial and local priorities forward. For 2017/18, there must exist a balance between the need to carry out important transitional work while, at the same time, ensuring the continuity of current LHIN operations, addressing the strategic directions and initiatives that form a basis for the LHIN's day-to-day work.

The following outline will be used to guide the communications and community engagement activities of the Central West LHIN, its Board of Directors and staff, in support of IHSP 2016-2019, ABP 2017/18, and LHIN transition in support of implementation of the Patients First Act.

Objectives

Successful implementation of any complex, large-scale, multi-sector communications strategy requires the integration and alignment of provincial and local objectives. Accordingly, this communications strategy considers both provincial and local objectives including:

LHIN Transition (Internal)

In collaboration with the Central West CCAC...

- Manage a smooth transition of CCAC and LHIN employees into the new LHIN organization
- Educate and inform CCAC and LHIN employees of the change that is occurring, the rationale for the change, and how the change will affect them
- Provide sustainable, two-way mechanisms for employees to stay informed and engaged during and after transition, as a united team
- Ensure robust change management approaches are utilized to support the transition.

LHIN Transition (External)

In collaboration with the Central West CCAC...

- Help broader stakeholders (HSPs, Service Provider Organizations (SPOs), patients/clients and the broader public) to further understand the Patients First Act and how it will improve the patient/client experience in the new LHIN organization
- Forge links between home and community care and primary care
- Raise awareness of work related to system access, particularly in regard to home and community care as well as primary care
- Build public confidence in the positive change taking place within their provincial and local health care systems
- Create awareness of LHIN sub-regions and how they will strengthen health care planning in the Central West LHIN
- Reassure broader stakeholder audiences that there will be no disruption in home care services to patients/clients.

LHIN Operational

- Develop and operationalize a Central West LHIN Patient and Family Advisory Committee
- Conduct the annual Central West LHIN Community Consultation Study
- Ensure development and operationalization of an integrated LHIN/CCAC patient complaint process for the new LHIN organization
- Educate and build broad stakeholder awareness of Central West LHIN strategic directions and initiatives identified in IHSP 2016-2019
- Raise awareness of the Central West LHIN's role, its unique characteristics, value proposition, caliber and credibility of work, and importance within the local health care system.
- Continue to build strong, trusted relationships with HSP communications teams across the Central West LHIN, working together to optimize communication resources and coordinated services.

Francophone and Indigenous Communities

The Central West LHIN includes a vibrant francophone community that is looking for better access to health care services in French. The LHIN is committed to working in collaboration with Reflet Salvéo, to better understand and implement effective, targeted communication strategies and tactics to meaningfully engage the Francophone community. To the same end, the LHIN will also seek to leverage existing channels including the FLS CAG.

The Central West LHIN's Indigenous communities have unique needs, and they must be engaged if the health care system is to meet those needs; from wellness to mental health, chronic disease management and palliative care perspectives. As indicated earlier in this Plan, the LHIN is committed to engaging Indigenous communities to ensure that their specific needs are understood. The LHIN is equally committed to engaging with Health Service Providers in an effort to raise their awareness of and need to promote the delivery of culturally competent care.

Stakeholder Audiences

Depending on the situation, primary and/or secondary stakeholders (audiences) will include:

- Patients and Caregivers
- General Public
  - Residents
  - Community Organizations
- Health Service Providers (Service Provider Organizations), Health Care Professionals, community partners and, as appropriate, surrounding LHINs:
  - Leadership, front line staff and Boards of Directors as required
  - Physicians, clinicians, health care professionals, caregivers (paid /unpaid)
  - Consumer/patient support groups
  - Health Care Associations (OHA, ONA, OMA, OLCA etc)
- Levels of Government
  - Municipal
  - Regional
  - Provincial (including MOHLTC and other ministries as appropriate)
- Media
- Other LHINs.

Strategic Approach

- Position the LHIN as a valued partner and leader in the transformation of provincial and local health care systems
- Develop sub-region approach to communications, focussing on uniqueness of different audiences, methods of communications and messages
- Improve system access and navigation for patients and families by raising further awareness of services and supports
- Position the work of the LHIN as a model for "Healthy Change" that successfully breaks down barriers, encourages collaborative work, shares knowledge and fosters partnerships among local, regional and provincial agencies

Tactics

- **Media:** In an effort to reach a variety of audiences, the Central West LHIN will seek to maintain and build upon existing relationships, while exploring new channels where deemed appropriate.
- **Print:** When and as required, the Central West LHIN will issue appropriate and timely news releases, opinion editorials and matte stories to educate and inform communities regarding the current happenings and goings on the local health care system.
- **Social / Online:** The Central West LHIN will look to formalize its presence with online/social media by devoting time and resources to establishing a formal social media policy, effectively managing new and existing content and committing to the development and use of interactive video content.
- **Publications:** While the LHIN will continue to design and publish regular, targeted newsletters to a variety of stakeholders, their number, frequency and method of delivery will be reviewed to ensure they are meeting the needs of the intended audiences.

- **Marketing Communications:** To support the further awareness of services and supports available to patients and families, develop appropriate and relevant print and electronic collateral, tailored to population health and sub-region stakeholder groups/audiences.
- **Stakeholder Events:** Whenever possible, the Central West LHIN Board and/or staff will participate in stakeholder engagement opportunities including but not limited to in-person town halls, telephone town halls, partner events, sponsored events, ground breaking ceremonies, facility openings, funding announcements, program/initiative announcements, and media opportunities.
- **Industry and Public Events/Conferences:** When and where deemed appropriate, the Central West LHIN Board of Directors and staff will continue to participate in key public health fairs and conferences at which they will have the opportunity to showcase LHIN activities, programs, achievements and successes.
- **Regional and Municipal Councils, and MPPs:** The LHIN will continue to meet regularly and communicate with regional, municipal and civic councils and MPPs across the area, to update them on achievements at the LHIN and to provide context on how work being done might impact their specific constituencies.
- **Brand Leveraging** – As local residents experience their health care system through their Health Service Providers, the Central West LHIN will seek to further leverage the brands and communication channels of key partners in order to more effectively deliver LHIN messages and information to local residents.

Key Messages

PROVINCIAL KEY MESSAGES

- The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre.
- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
  - We have made progress in all four priority areas, but we can do more to put patients first.
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.
- On December 7, 2016, Ontario passed the Patients First Act, 2016, an important step forward in the *Patients First: Action Plan for Health Care*.
- Once fully implemented, changes supported by the Patients First Act will make local health care more responsive to local needs:
  - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner.
  - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once.

- Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care.
- The voices of patients and families in their own health care planning will be strengthened.
- There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.

- LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care.

LHIN KEY MESSAGES

LHIN Transition (Patients First Act)

- The Patients First Act is part of the government's *Patients First*: Action Plan for Health Care to create a more patient-centered health care system in Ontario.
- Under the Patients First Act, new LHIN organizations will bring together the best of both LHIN and CCAC organizations to ensure patients are getting better coordinated care, and that the health system is more integrated and responsive to local needs.
- Over the past decade, Ontario's care providers and health system partners have worked hard to deliver vital care to patients and their families. With many meaningful successes across the system, there are opportunities for primary care and the home and community care sectors to work more closely together to ensure patients experience a more seamless journey across the continuum.

LHIN Transition (Sub-Regions)

- Under the Patients First Act smaller geographic planning regions have been established within each LHIN to help LHINs to better understand and address patient needs at the local level.
- Sub-regions are smaller geographic planning areas that will help to better understand and address population health needs at the local level.
- By looking at care patterns through a smaller lens, LHINs will be able to better identify and respond to community needs and work with local health system leaders, including family doctors, nurse practitioners, home care coordinators and home and community care service providers, to build more seamless local health care service delivery.
- Sub-regions are not separate organizations and they will not add an additional layer of administration. They will not have their own staff or boards of directors, but rather are part of existing neighbourhood-focused operations.
- Central West LHIN sub-regions are aligned with and identical to existing Health Links boundaries including Bolton–Caledon, Bramalea and Area, Brampton and Area, Dufferin and Area, and North Etobicoke–Malton–West Woodbridge.

LHIN Transition (Service Delivery)

- Ontario is making changes to the healthcare system, to increase access, reduce wait times, and improve the patient experience.

- The Patients First Act creates a single-point of accountability for home and community care regionally, with responsibility moving to a new LHIN organization that brings together the best of both CCAC and LHIN legacy organizations.
- Changes brought about by the Patients First Act relate to the oversight and structure of a new LHIN organization, and do not mean any changes to the services currently being provided in the home or community.
- There will be no disruption to patient care —family doctors and other health care providers will remain the same, but they will be better able to help patients get the care they need.

LHIN Operations

- Together with local partners, the Central West LHIN continues to bring about significant and positive change to ensure better patient outcomes.
- The Central West LHIN remains committed to building a more seamless and coordinated approach to patient care.
- The Central West LHIN is improving value in the system by identifying opportunities for local service providers to work better together to reduce duplication and delays, and avoid unnecessary costs.

Communication Tools

Tools	Timeline(s)	Responsibility	Context
News Releases	As required, to highlight/promote Central West LHIN activities/events.	Communications	In conjunction with program areas as required.
Success Stories	Support timely/effective impact of good news on appropriate audience(s).	Program Leads	Program areas will "feed" material to Communications.
eNews	Monthly newsletter to a general audience.	Communications	Info and fact-checking by program area.
Community Update	Semi-annual publication to recap and check in on progress made throughout the fiscal year.	Communications	Info and fact-checking by program area.
MPP / Municipal Briefing Notes (Updates)	Sent to MPP's and municipal leaders monthly.	Communications	Fed from monthly CEO update to the Board.
MPP Meetings	Quarterly	Central West LHIN Board Chair and CEO	With support from communications.

Governance and Leadership Forums	Quarterly	Communications	Support provided to Board of Directors.
Regional, Municipal, Civic Council Meetings	Meet/present to these bodies regularly, contingent on schedule availability.	Central West LHIN Board Chair and CEO	With support from communications.
Conferences	As appropriate.	Relevant program area aligned to topic or theme of event.	None.
Speakers bureau (opportunities)	As appropriate.	CEO, Senior Directors to identify opportunities	Speaking notes supplied by Communications as required.
Board Materials	Ahead of and following monthly Board meetings.	Board and CEO Liaison	None.
Media Outreach – Print, Broadcast, Online	Ongoing	Communications	Participation by program area(s) for background and/or education.
Website – Content Management and Updating	Ongoing	Communications	Preparation and postings of materials to be handled by program area, with vetting by Communications to ensure messaging content and tone.
MOHLTC Requests for information/ analysis	As required. Usually on immediate turnaround.	Communications to coordinate with input from program areas.	None
French Language Services (FLS) coordination	As required to further Central West LHIN and/or Reflet Salvéo with communications plans.	FLS Coordinator, with assistance from Communications	None

Evaluation

Identifying and tracking communication success factors enables the Central West LHIN to more effectively identify whether communication activities have been successful. Using the following measures, a formal and comprehensive evaluation of the LHIN's communications efforts will be carried out in-house.

- Annual Community Consultation Study to assess public awareness of and satisfaction with their local health care system.
- Website traffic: using analytics, pages and specific postings are tracked
- Evaluate LHIN community engagement by monitoring and measuring tone and volume of traditional media, online/social media, and LHIN communication vehicles (emails, bulletins)
- Event participation and feedback
- Visible senior leadership engagement and support for the communications & community engagement activities associated with the IHSP 2016-2019 strategic directions and ABP 2016/2017 initiatives
- Active participation of LHIN Board Members in support of communications & community engagement.
- A clear understanding, by key stakeholders, of the LHIN's strategic and operational plans, and how they play a role towards their successful realization.
- The appropriate, early and frequent engagement of HSPs to demonstrate how their ongoing participation impacts successful realization of desired outcomes.
- The use of feedback mechanisms and ongoing assessment tools to monitor the effectiveness of communication vehicles and messages.

BOARD OF DIRECTORS

Carmine Domanico
Chair
June 8/17 – June 7/20

Adrian Bita
Director
May 6/15 – May 5/18

Neil Davis
Director
Nov. 28/16 – Nov. 27/19

Dr. Hugh O'Brodovich
Director
May 31/17 – May 30/20

Jeff Payne
Director
May 27/15 - May 26/18

Not Pictured

Anita Gittens, Director	June 14/17 - June 13/20
Peter Harris, Director	March 1/17 - February 28/20
Ashish Kemkar, Director	March 1/17 - February 28/20
Moyra Vande Vooren, Director	April 12/17 - April 11/20

Past Members

*Maria Britto, Past Chair	June 9/11 – June 8/14 and June 9/14 – June 8/17
*Suzan Hall, Director	May 17/11 – May 16/14 and May 17/14 – May 16/17
*Pardeep Singh-Nagra, Director	June 9/11 – June 8/14 and June 9/14 – June 8/17

** Denotes Reappointment*

Central West **LHIN**

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The Central West LHIN Annual Business Plan 2017/18 is available in both English and French.